February 1999

FISCAL YEAR 1999

APPLICANT INFORMATION INSTRUCTION BOOKLET

Indian Health Service Scholarship Programs

PART TWO

Application Instructions and Forms

Due Date: April 1, 1999

Submit to: Area Scholarship Coordinator

Department of Health and Human Services
Public Health Service
Indian Health Service

LIST OF ITEMS IN THE APPLICATION PACKET

The following items are contained in the application packet which you have received:

1. Cover Memorandum
2. Application for participation in the IHS Scholarship Program (Form IHS-856)
3. Applicant Information—Instruction Booklet (1999-2000 Awards)
4. Return Envelope
5. Indian Health Scholarship Program Contract (Form IHS-818)
6. Envelope — for Indian Documentation

The back cover of Application Information—Instruction Booklet consists of:

1. Postcard for Acknowledgment of Receipt of Application (Form IHS-815)
   Enter your name and address on the front of the acknowledgment postcard and submit it along with your application. This card will be mailed back to you within 4 weeks of receipt of your application and should be retained in your records.
2. Change of Address Card (Form IHS-816).
   Retain this card for possible future use. Should your address change, complete the card with the new address and return it to the scholarship program.

If any of these items are missing, contact the IHS Scholarship Area Coordinator or the Grants Management Branch immediately.

POWER-OF-ATTORNEY

If you are submitting and executing an application on behalf of a person from whom you have been granted Power-of-Attorney, it is mandatory that a copy of the agreement granting Power-of-Attorney be submitted with the application materials.

GENERAL DIRECTIONS

APPLICATION

All applicants Must Sign Page 12 of the "APPLICATION FOR PARTICIPATION IN: THE INDIAN HEALTH SERVICE SCHOLARSHIP PROGRAMS" Below "SECTION F: CERTIFICATION" Where it states "SIGN YOUR FULL NAME IN INK AND DATE". FAILURE TO SIGN PAGE 12 OF THE APPLICATION WILL RESULT IN YOUR APPLICATION NOT BEING CONSIDERED.

Do not make any entries on the application until you have read the directions. Errors of omissions on the form will delay or prevent the processing of your application.

Use a No. 2 lead pencil for all entries. Sign your name in ink under Section D, "CERTIFICATION SIGNATURE."

DIRECTIONS FOR COMPLETING THE APPLICATION

(Instructions are given only for selected items on the application.)

Front page: blacken appropriate academic year.

SECTION A: GENERAL INFORMATION

Section A-1. Discipline or prerequisite track:

Write in the name of your program, then enter the alpha code corresponding to this program. ***If your program is not listed on pages 3, 4, and 5, you are not eligible for an IHS Scholarship.***

Health Professions Prepartaory:

PAC	Preaccounting
PDI	Predietetics
PMT	Premedical Technology
PNU	Prenurse
PPH	Prepharmacy
PSW	Pre Social Work
PPT	Pre Physical Therapist

Health Professions Pregraduate:

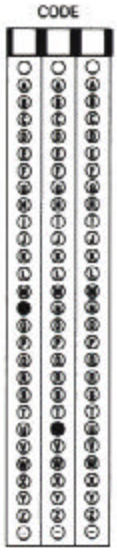
PDD	Predentistry
PMD	Premedicine

Health Professions Scholarship:

ACC	Accounting, B.S.
ADA	Chemical Dependency Counseling
BS	Business Administration
CP	Clinical Psychologist
CSC	Computer Science
DD	Dentist
DI	Dietician
DO	Physician, Osteopathy
HE	Health Educator
HRC	Health Records
MBA	Business Administration
MD	Physician, Allopathy
MDT	Medical Technology
MPH	Masters Public Health (MPH)
MSN	Nurse with minimum of a Masters Degree
NM	Nurse Midwife
NP	Nurse Practitioner (RNA or FNP)
ADN	Associate Degree Nurse
NU	Nurse with minimum of a Baccalaureate Degree in Nursing (BSN)
OPT	Optometrist
PA	Physician's Assistant
PH	Pharmacist
PHN	Public Health Nutritionist
POD	Podiatrist
PT	Physical Therapist
RT	Respiratory Therapist
SW	Social Worker (Medical)
XRY	X-Ray Tecnology (Radiology)
SON	Ultrasonagrapher
POT	Parsoptometrics

For example, if you are pursuing a Nursing degree (BSN), you would enter: NU

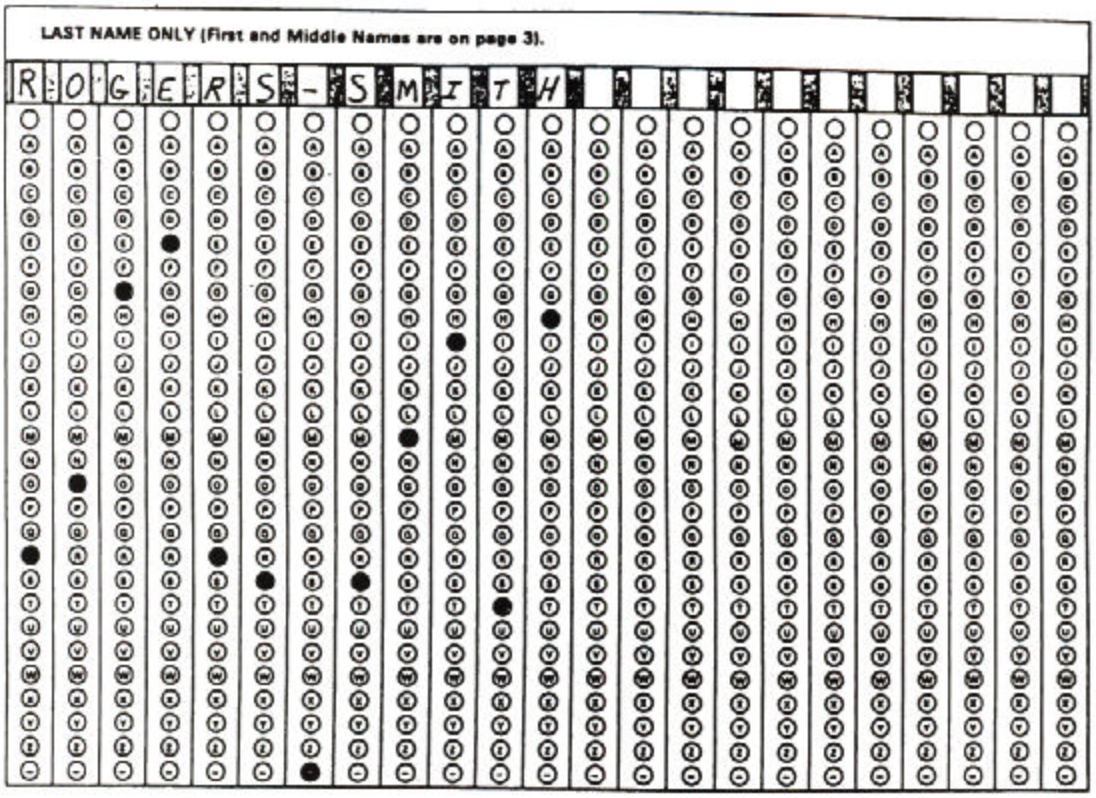
Name of degree program: N U R S I N G



Section A-2. Full Name:

Print your last name, first name, and middle name in the two sets of boxes provided. Begin in the first box of each set and print only one letter per box. Print your last name only in the first set of boxes and your first and middle name only in the second set of boxes. In the column below each box, blacken the circle that corresponds to the letter, symbol, or empty box. Be sure to blacken a circle on every column.

EXAMPLE OF LAST NAME:
William John Rogers-Smith



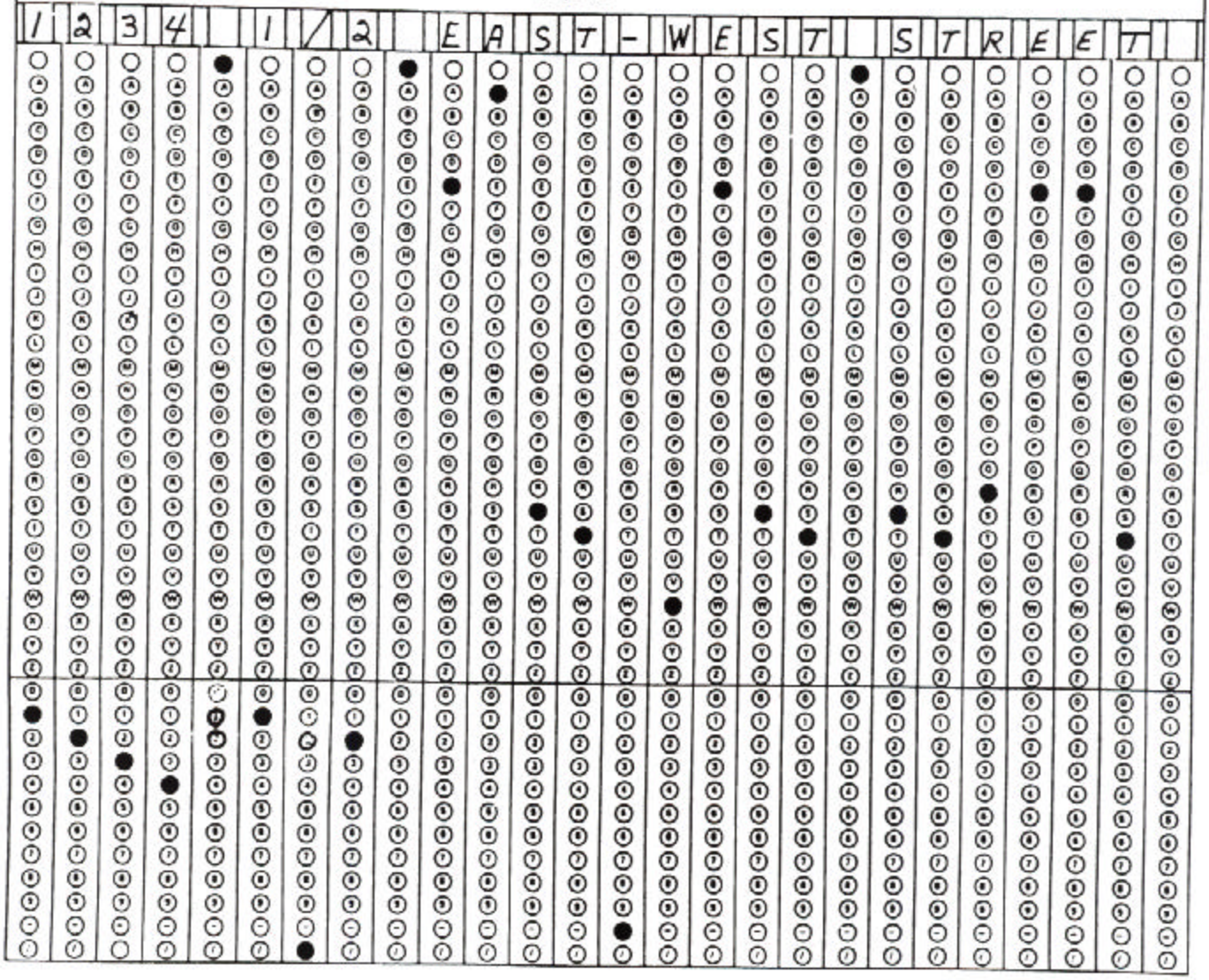
Section A-3. Street Address. ***(Do not put city, state, or zip code in this grid.)***

Beginning in the first box, print the address where you now receive mail, one number or letter per box. Leave one empty box between the parts of your address. Abbreviations may be used. In the column that extends below each box, blacken the circle that corresponds to the number, symbol, or empty box. It is important that the address you give is your *current* mailing address.

EXAMPLE OF FIRST LINE OF STREET ADDRESS:

1234 ½ East-West Street

FIRST LINE OF STREET ADDRESS ONLY (Second line is on page 5).



ction A-4-d

cken the 2-digit code for the IHS area office where you submitting your application.

ction A-6. Social Security Number:

plicants who are selected to the Scholarship Program will required to furnish their Social Security Number for the rment of their stipend for Federal tax purposes. (See vacy Act Notification Statement on page iv.) The number used for identification purposes only; no sums are hheld from stipend payment for participation in the Social curity Retirement System (FICA). Applicants without a cial Security Number should make immediate efforts to tain one by calling their local office of the Social Security ministration.

ction A-9

vide official evidence of tribal membership as follows:

. If you are a member of a Federally recognized tribe (recognized by the Secretary of Interior), provide evidence of membership such as:

   1) Certification of tribal enrollment by the Secretary of Interior, acting through the Bureau of Indian Affairs (BIA Certification: Form 4432 – Category A or D, whichever is applicable; or

   2) In the absence of BIA certification, documentation that you meet requirements of tribal membership as prescribed by the charter, articles of incorporation or other legal instrument of the tribe and have been officially designated as a tribal member as evidenced by an accompanying document signed by an authorized tribal official, or

   3) Other evidence of tribal membership satisfactory to the Secretary of Interior.

. If you are a member of a tribe terminated since 1940 or a State recognized tribe, provide official documentation that you meet the requirements of tribal membership as prescribed by the charter, articles of incorporating or other legal instrument of the tribe and have been officially designated as a tribal member as evidence by an accompanying document signed by an authorized tribal official; or other evidence, satisfactory to the Secretary of Interior, that you are a member of the tribe. In addition, if the terminated or State recognized tribe of which you are a member is not on a list of such tribes published by the Secretary of Interior in the Federal Register, you must submit an official signed document that the tribe has been terminated since 1940 or is recognized by the state in which the tribe is located in accordance with the law of that state.

. If you are not a tribal member but are a natural child or grandchild of a tribal member, you must submit (1) evidence of that fact, e.g., your birth certificate and/or your parent's birth certificate showing name of tribal member, and (2) evidence of your parent's or grandparent's tribal membership in accordance with paragraphs A and B. The relationship to the tribal member must be clearly documented.

   NOTE: If you meet the criteria of B or C you are eligible only for the Preparatory or Pregraduate Scholarships.

ction A-13. Conflicting Service Obligation:

udents already obligated to a State or other entity for ofessional practice after academic training should not ply for IHS Scholarship awards unless they have ascerned that there is no potential conflict in fulfilling the rvice obligation to the State or other entity and to the Scholarship Program, and that the Scholarship Program service will be served first.

If you are obligated to practice under another program, read the terms of your agreement carefully. Many agreements will enable you to serve the IHS Scholarship obligation first. If so, there is no conflict, and you should blacken the answer "no" and submit with your application a written statement of non-conflict from the other program.

Scholarship recipients not immediately available after authorized deferments to fulfill the Scholarship service obligation are in breach of their Scholarship Program contracts described in this *Information Booklet*.

Section A-14 Future Specialty Interest

Family Practice	FP	General Psychiatry	GPSY
Internal Medicine	INT	Child Psychiatry	CPSY
Pediatrics	PED	Emergency Medicine	EM
Obstetrics/Gynecology	OBGYN	General Surgery	GSUR

Write the name of your specialty interest in the block and enter alpha code. If you have no specialty preference at present, enter the word UNKNOWN in the block and blacken unknown in the specialty code blocks.

NOTE: All residencies require prior approval.

Section A-15. Permanent Recipient Address

Indicate the PERMANENT address at which you may be contacted during the period of the scholarship award. This should be the address of a parent, relative, or any other address which will not change.

It is mandatory that approved scholarship applicants receive monthly stipend payments via bank direct deposit. Stipend payments are electronically deposited in your bank account on or before the first day of the month. Contact your bank to obtain and complete correctly the direct deposit form which must be submitted to the IHS.

You must obtain a post office box in the city where you will live while attending school. ALL correspondence issued to you during the first year of the scholarship will be sent to this post office box. You will receive $35 to cover the cost of your post office box rental.

After you have arranged for direct deposit or a post office box, you must submit the "Verification of Acceptance or Decline of Award" form. This form is Attachment VI in the application booklet. Send form to the IHS, Grants Management Branch, Suite 100, 12300 Twinbrook Parkway, Rockville, Maryland 20852.

DIRECT DEPOSIT INFORMATION WILL NOT BE CHANGED DURING THE ENTIRE FIRST YEAR OF SCHOLARSHIP FUNDING. You will *not* be allowed to change banks unless you change schools and relocate to another city. This assures that no matter where or how many times you move there is one permanent location for you to receive your stipend.

Section A-16. Employee's Withholding Allowance (Form W-4)

Scholarship stipend benefits paid are subject to Federal income taxation. To comply with tax withholding requirements in the event you are selected, you must complete the W-4 Form included in your application packet. If you do not wish tax withheld from your monthly stipend check, you should claim exempt on the W-4 form and do not fill in A-14 item b. After you have completed Form W-4, fill out the information requiested in Section A-16 of the application.

If you have questions regarding the Form W-4, contact your local Internal revenue Service office.

COMPLETION OF SUPPLEMENTAL FORMS
(Please see booklet)

PART II

Attachment 1 - Course Curriculum Verification
For students in all three scholarship programs who are changing to the Health Professions Preparatory program, fill in your name, social security number, and career category and indicate the section applicable to you. Identify all courses you plan to take each semester or quarter by specific course number, credit hours, and course title. Your college advisor or counselor must sign this form, indicate their correct title, and date the form. Your advisor or counselor should return the form *directly to you* so you may include it to be submitted with your application.

Attachment II - Faculty/Employer Evaluation Forms (2)

Provide two (2) completed Faculty/Employer Forms. These evaluations will be used as part of your rating. Arrange to pick up the completed forms yourself to include in your application so that all required documents are present to make your application complete. DO NOT SEND LETTERS OF RECOMMENDATION IN LIEU OF THIS FORM. This attachment is subject to a statement of conflict of interest.

Attachment III - Reasons for Requesting Scholarship

Each applicant must provide a brief written explanation of his/her reason for asking for the scholarship and of his/her career goals. It is important that this narrative is written with good grammar, clarity and organization. It will be used as part of your rating. Type or print narrative legibly so it may be read. You will not be rated on material that cannot be read.

Attachment IV - Delinquent Federal Debt Form

Each applicant must complete and forward this sheet with the application and required documents.

Attachment V - Work Experience – *Optional*

To be considered for a scholarship for a Masters in Public Health, you must have a degree in a health related discipline and be accepted into an MPH program.

Attachment VI - Verification of Acceptance or Decline of Award

Do not mail this form with your application. Retain and mail to the IHS Grants Management Branch only if notified of an offer of a scholarship award.

Attachment VII - Form W-4

All applicants must complete and forward this form with the application.

PART III - Application Checklist

All applicants must complete and forward this checklist with the application. Place a checkmark in the box under the STUDENT Column for those items applicable to your application. Indicate N/A for any items not specifically applicable to you.

PART IV - Application Receipt Card (IHS-815)

ADDITIONAL DOCUMENTS REQUIRED WITH APPLICATION

Each of the documents listed below must be received with your application on April 1, 1999. Incomplet or late applications will not be considered for funding.

DOCUMENTATION FOR INDIAN ELIGIBILITY—

See Section A-9, page 18 herein.

OFFICIAL TRANSCRIPT—

You must submit an official transcript for all course work taken during the Fall and/or Winter, 1998-1999, semester/quarters. It is important that you submit all transcripts.

Provide one original OFFICIAL TRANSCRIPT from each college university you have attended. Official Transcript means the institutional seal and/or the signature of the registrar *MUST* be present. If you have not attended a college or university, submit official transcripts from your high school. If you did not graduate from high school, submit a copy of an official document which verifies high school equivalency. The cumulative grade point average will be determined from the official transcript(s). The GPA is one of the factors included in your final application rating.

EVIDENCE OF ACCEPTANCE TO SCHOOL—

If you are a new applicant or if you are changing from the Health Professions Preparatory or Pregraduate Scholarship to a Health Professions Program, changing career categories, or changing schools, you *must* submit a copy of a letter of acceptance or admission from the school. In the absence of a letter of acceptance from the school, a letter from the school which indicates that you have applied for admission and the date formal acceptance will be given will be acceptable. However, if you submit a letter verifying your application, you *MUST* follow-up with evidence of official acceptance by the school no later that **June 1, 1999**, for your scholarship application to be funded. All new applicants must submit a letter of acceptance or admission from the school they will be attending. This letter is to be submitted with the application.

NOTE: SPECIAL INSTRUCTIONS

Health Professions Preparatory Applicants—

You must submit verification that the courses or curriculum are required to meet your educational deficiency or is preparatory for acceptance into a health program and that the educational program represents a full-time course load or at least six credit hours for part-time students (Attachment III).

Health Professions Pregraduate Applicants—

You must submit verification that the curriculum for which you will enroll will lead to a bachelor's degree and will prepare you for acceptance into a school of medicine or dentistry upon its completion; a part-time course must be a minimum of six credit hours (Attachment III).

Health Professions Applicants—

You must submit evidence of acceptance into the specified health professions educational program for which you are requesting scholarship support, e.g. nursing, medicine, etc. A letter of general admission to a school will not be acceptable and will cause your application to be considered incomplete.

Documentation must be received from part-time applicants that their school and course curriculum allows less than full-time status. A part-time curriculum must be a minimum of six credit hours.

Instructions for Scholarship Contract— (form IHS-818) Completed by Health Professions Applicants

This contract is applicable to Health Profession scholarship applicants only. *READ THE CONTRACT CAREFULLY.*

Your obligations are defined in Section B - Obligations of the Applicant.

You may be liable for breach of contract if you fail to maintain an acceptable level of academic standing in course studies, or fail to begin or complete obligated service under the contract. See IHS Scholarship Program Contract: Section C - Breach of Scholarship Contract.

Sign and date the contract. Return the first 4 copies, keep the 5th copy which has "Sample" imprinted on it for your records. A copy of your official signed contract will be mailed to you after the Secretary has signed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

FORM APPROVED:
OMB Approval No. 0917-0006
Exp. Date: 4/30/2001

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437—TITLE I SCHOLARSHIP PROGRAM COURSE CURRICULUM VERIFICATION

REGARDING	STUDENT'S NAME	SOCIAL SECURITY NUMBER
	CAREER CATEGORY	

(Check one)

- ☐ HEALTH PROFESSIONS PREGRADUATE – Section 103 (b)(2)
- ☐ HEALTH PROFESSIONS PREPARATORY – Section 103 (b)(1)
- ☐ HEALTH PROFESSIONS – Section 104

THIS FORM MUST BE SIGNED BY THE APPROPRIATE COLLEGE OR UNIVERSITY OFFICIAL

This verifies that the individual referenced above has applied for admission or is enrolled at (Name of College/ University) _____ for the academic year 1999-2000. He/She will be enrolled in either a full-time or part-time (circle one) undergraduate curriculum leading to a bachelor's degree in premedicine; or a preparatory curriculum which fulfills the requirement for admission into his/her chosen health program of _____; or the student is enrolled in a health professional program that is eligible for funding under this scholarship program. The individual will be enrolled/or is anticipated to be enrolled in the following courses **commencing Fall 1999.**

SEMESTER I OR QUARTER I — TOTAL S/Q I HOURS: _____

COURSE NUMBER	*CREDIT HOURS*	*COURSE TITLE*

SEMESTER II OR QUARTER II — TOTAL S/Q II HOURS: _____

COURSE NUMBER	*CREDIT HOURS*	*COURSE TITLE*

QUARTER III — TOTAL Q III HOURS: _____

COURSE NUMBER	*CREDIT HOURS*	*COURSE TITLE*

ADVISOR OR COUNSELOR SIGNATURE	TITLE	DATE

IHS-856-3
(REV. 5/94)

5/4647C

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 42 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it display a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 12300 Twinbrook Parkway, Suite 450, Rockville, MD 20852-1006, ATTN: PRA (0917-0006). Do not return the completed form to this address.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

FORM APPROVED:
OMB Approval No. 0917-0006
Exp. Date: 4/30/2001

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437—TITLE I SCHOLARSHIP PROGRAM FACULTY/EMPLOYER EVALUATION

REGARDING	STUDENT'S NAME	SOCIAL SECURITY NUMBER
	CAREER CATEGORY	

The student identified above is applying to receive an Indian Health Service (IHS) Scholarship. The information on this form is requested pursuant to Section 751-756 of the Public Health Service Act, as amended, and applicable program regulations which provide that, in evaluating and selecting individuals for scholarships, consideration will be given to faculty or employer recommendations.

The information provided on this form is treated as confidential and may only be disclosed outside the Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register*.

PLEASE RETURN COMPLETED FORM TO APPLICANT

1. How do you rate the educational/work achievement of this applicant?

5 - ☐	4 - ☐	3 - ☐	2 - ☐	0 - ☐
OUTSTANDING	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	POOR

2. How do you rate the applicant's relationships with other people? Consider such things as ability to work and get along with others.

5 - ☐	4 - ☐	3 - ☐	2 - ☐	0 - ☐
OUTSTANDING	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	POOR

3. Based on this applicant's personal, emotional, ethical attributes, how do you rate his/her over-all potential for the practice of primary health care, especially in a health manpower shortage area?

5 - ☐	4 - ☐	3 - ☐	2 - ☐	0 - ☐
OUTSTANDING	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	POOR

Please provide written comments:

Type of work: _____

Length of time known: _____

Statement of Conflict of Interest: I certify I am not related to applicant by blood or marriage.

NAME (Print or type)	SIGNATURE	DATE

TITLE OF POSITION	PLACE OF EMPLOYMENT

IHS-856-4 (12/93)

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 60 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it display a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 12300 Twinbrook Parkway, Suite 450, Rockville, MD 20852-1006, ATTN: PRA (0917-0006). Do not return the completed form to this address.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

FORM APPROVED:
OMB Approval No. 0917-0006
Exp. Date: 4/30/2001

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437—TITLE I SCHOLARSHIP PROGRAM FACULTY/EMPLOYER EVALUATION

REGARDING	STUDENT'S NAME	SOCIAL SECURITY NUMBER
	CAREER CATEGORY	

The student identified above is applying to receive an Indian Health Service (IHS) Scholarship. The information on this form is requested pursuant to Section 751-756 of the Public Health Service Act, as amended, and applicable program regulations which provide that, in evaluating and selecting individuals for scholarships, consideration will be given to faculty or employer recommendations.

The information provided on this form is treated as confidential and may only be disclosed outside the Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register*.

PLEASE RETURN COMPLETED FORM TO APPLICANT

1. How do you rate the educational/work achievement of this applicant?

5 - ☐	4 - ☐	3 - ☐	2 - ☐	0 - ☐
OUTSTANDING	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	POOR

2. How do you rate the applicant's relationships with other people? Consider such things as ability to work and get along with others.

5 - ☐	4 - ☐	3 - ☐	2 - ☐	0 - ☐
OUTSTANDING	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	POOR

3. Based on this applicant's personal, emotional, ethical attributes, how do you rate his/her over-all potential for the practice of primary health care, especially in a health manpower shortage area?

5 - ☐	4 - ☐	3 - ☐	2 - ☐	0 - ☐
OUTSTANDING	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	POOR

Please provide written comments:

Type of work: _____

Length of time known: _____

Statement of Conflict of Interest: I certify I am not related to applicant by blood or marriage.

NAME (Print or type)	SIGNATURE	DATE

TITLE OF POSITION	PLACE OF EMPLOYMENT

IHS-856-4 (12/93)

6/4947C

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 50 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it display a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 12300 Twinbrook Parkway, Suite 450, Rockville, MD 20852-1006, ATTN: PRA (0917-0006). Do not return the completed form to this address.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

FORM APPROVED:
OMB Approval No. 0917-0006
Exp. Date: 4/30/2001

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437—TITLE I SCHOLARSHIP PROGRAM
REASONS FOR REQUESTING SCHOLARSHIP

APPLICANT'S NAME	CAREER CATEGORY
SOCIAL SECURITY NUMBER	INDIAN HEALTH SERVICE OFFICE APPLYING THROUGH

Explain why you are requesting this scholarship **

State your career goals **

Explain how these goals will help to meet the health needs of the Indian people **

** *If more space is required, use back of last page of application or full sheets, the same size as this page. Write on each sheet your name and social security number. Securely attach all sheets to this application.*

IHS-856-5
(REV. 5/94)

6/4917C

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 45 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it display a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 12300 Twinbrook Parkway, Suite 450, Rockville, MD 20852-1006, ATTN: PRA (0917-0006). Do not return the completed form to this address.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

FORM APPROVED:
OMB Approval No. 0917-0006
Exp. Date: 4/30/2001

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437—TITLE I SCHOLARSHIP PROGRAM
DELINQUENT FEDERAL DEBT FORM
(Required form)

APPLICANT'S NAME	CAREER CATEGORY
SOCIAL SECURITY NUMBER	INDIAN HEALTH SERVICE OFFICE APPLYING THROUGH

INSTRUCTIONS:

The applicant must complete and forward this sheet with the application and required documents. Please check the appropriate box below. If the "Yes" box is checked, please provide an explanation in the space provided.

Examples of Federal Debt include delinquent taxes, audit disallowances, guaranteed or direct student loans, FHA loans, and other miscellaneous administrative debts. The definition of delinquency for the purposes of direct and guaranteed loans are any loan(s) more than 31 days past due on a scheduled payment. Deferred loans are not considered delinquent by the Indian Health Service.

ARE YOU DELINQUENT ON THE REPAYMENT OF ANY FEDERAL DEBT(S)?

☐ No ☐ Yes

If your response was "Yes," please provide an explanation in the space provided below. Explanation must include name of Federal Agency *(Debt)*, type *(student loan, HUD Mortgage, etc.)*, telephone number and name of contact person(s) handling debt, and account number if different from your SSN. You must also provide a notarized power of attorney authorizing IHS Grants Management Branch personnel to inquire on your debt. If authorization is not included, your application will not be considered for an award.

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any willfully false representation is sufficient cause for rejection of this application, or, if awarded a Scholarship, that I am liable for repayment of all awarded funds and, further, that any false statement herein may be subject to penalties under U.S. code, Title 18, Section 1001.

APPLICANT'S SIGNATURE	DATE

IHS-856-6
(REV. 5/94)

0/4947C

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 8 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it display a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 12300 Twinbrook Parkway, Suite 450, Rockville, MD 20852-1006, ATTN: PRA (0917-0006). Do not return the completed form to this address.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

FORM APPROVED:
OMB Approval No. 0917-0006
Exp. Date: 4/30/2001

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437—TITLE I SCHOLARSHIP PROGRAM
PUBLIC HEALTH *(MPH)* ONLY *(Optional)*

NAME OF APPLICANT	CURRENT CAREER CATEGORY
SOCIAL SECURITY NUMBER	INDIAN HEALTH SERVICE OFFICE APPLYING THROUGH

HEALTH RELATED JOBS OR VOLUNTEER EXPERIENCE *(BEGIN WITH MOST RECENT WORK EXPERIENCE)*

A. EXACT TITLE OF YOUR POSITION

DATES EMPLOYED *(Give Month & Year)* FROM: TO:

Average # of Hrs. Worked per Week

STATUS
PAID ☐ Yes ☐ No
VOLUNTEER ☐ Yes ☐ No

DESCRIPTION OF WORK ***(Briefly describe your specific duties, responsibilities and accomplishments in the position)***

B. EXACT TITLE OF YOUR POSITION

DATES EMPLOYED *(Give Month & Year)* FROM: TO:

Average # of Hrs. Worked per Week

STATUS
PAID ☐ Yes ☐ No
VOLUNTEER ☐ Yes ☐ No

DESCRIPTION OF WORK ***(Briefly describe your specific duties, responsibilities and accomplishments in the position)***

C. EXACT TITLE OF YOUR POSITION

DATES EMPLOYED *(Give Month & Year)* FROM: TO:

Average # of Hrs. Worked per Week

STATUS
PAID ☐ Yes ☐ No
VOLUNTEER ☐ Yes ☐ No

DESCRIPTION OF WORK ***(Briefly describe your specific duties, responsibilities and accomplishments in the position)***

D. EXACT TITLE OF YOUR POSITION

DATES EMPLOYED *(Give Month & Year)* FROM: TO:

Average # of Hrs. Worked per Week

STATUS
PAID ☐ Yes ☐ No
VOLUNTEER ☐ Yes ☐ No

DESCRIPTION OF WORK ***(Briefly describe your specific duties, responsibilities and accomplishments in the position)***

E. EXACT TITLE OF YOUR POSITION

DATES EMPLOYED *(Give Month & Year)* FROM: TO:

Average # of Hrs. Worked per Week

STATUS
PAID ☐ Yes ☐ No
VOLUNTEER ☐ Yes ☐ No

DESCRIPTION OF WORK ***(Briefly describe your specific duties, responsibilities and accomplishments in the position)***

IHS-856-7
(REV. 5/94)

6/4047(

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 50 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it display a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 12300 Twinbrook Parkway, Suite 450, Rockville, MD 20852-1006, ATTN: PRA (0917-0006). Do not return the completed form to this address.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

FORM APPROVED:
OMB Approval No. 0917-0006
Exp. Date: 4/30/2001

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437—TITLE I SCHOLARSHIP PROGRAM VERIFICATION OF ACCEPTANCE OR DECLINE OF AWARD

RETAIN THIS ATTACHMENT UNTIL YOU ARE NOTIFIED OF YOUR SELECTION AS A SCHOLARSHIP RECIPIENT. DO NOT MAIL THIS FORM WITH YOUR APPLICATION SUBMISSION.

REGARDING	STUDENT'S NAME	SOCIAL SECURITY NUMBER
	INDIAN HEALTH SERVICE OFFICE APPLYING THROUGH	

Please indicate your acceptance or decline of an Indian Health Service Scholarship award by checking the appropriate space below. Scholarship award will not be issued until this form is completed and returned.

☐ I accept the scholarship award for the 1999-2000 school year.

☐ I decline the scholarship award for the 1999-2000 school year.

If you accept the award, you must immediately arrange for a post office box to serve as your permanent recipient mailing address to which correspondence will be sent during the entire first year of scholarship funding.

Please complete the following information.

☐ I have arranged for the following post office box during the 1999-2000 school year:

POST OFFICE BOX NUMBER		
CITY	STATE	ZIP CODE

☐ Please note this is a change of address

Complete this form and return immediately to:

Indian Health Service
Grants Management Branch
Division of Acquisition and Grants Operations
12300 Twinbrook Parkway, Suite 100
Rockville, Maryland 20852

If you have any questions, please contact your Area Scholarship Coordinator.

RETAIN THIS ATTACHMENT UNTIL YOU ARE NOTIFIED OF YOUR SELECTION AS A SCHOLARSHIP RECIPIENT. DO NOT MAIL THIS FORM WITH YOUR APPLICATION SUBMISSION.

Signature: _____ Date: _____

IHS-856-6
(REV. 6/94)

6/4947C

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 8 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it display a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 12300 Twinbrook Parkway, Suite 450, Rockville, MD 20852-1006, ATTN: PRA (0917-0006). Do not return the completed form to this address.

Form W-4 (1999)

Purpose. Complete Form W-4 so your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7, and sign the form to validate it. Your exemption for 1999 expires February 16, 2000.

Note: *You cannot claim exemption from withholding if (1) your income exceeds $700 and includes more than $250 of unearned income (e.g., interest and dividends) and (2) another person can claim you as a dependent on their tax return.*

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. They will help you figure the number of withholding allowances you are entitled to claim. **However, you may claim fewer allowances.**

Child tax and higher education credits. For details on adjusting withholding for these and other credits, see **Pub. 919,** Is My Withholding Correct for 1999?

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line E below.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, you should consider making estimated tax payments using Form 1040-ES. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding will usually be most accurate when all allowances are claimed on the Form W-4 prepared for the highest paying job and zero allowances are claimed for the others.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your estimated total annual tax. Get Pub. 919 especially if you used the Two-Earner/Two-Job Worksheet and your earnings exceed $150,000 (Single) or $200,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

Personal Allowances Worksheet

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . A ____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.

. . B ____

C Enter "1" for your **spouse.** But, you may choose to enter -0- if you are married and have either a working spouse or more than one job. (This may help you avoid having too little tax withheld.) . . . . . C ____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . D ____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . E ____

F Enter "1" if you have at least **$1,500** of **child or dependent care expenses** for which you plan to claim a credit . . F ____

G **Child Tax Credit:** • If your total income will be between $20,000 and $50,000 ($23,000 and $63,000 if married), enter "1" for each eligible child. • If your total income will be between $50,000 and $80,000 ($63,000 and $115,000 if married), enter "1" if you have two eligible children, enter "2" if you have three or four eligible children, or enter "3" if you have five or more eligible children . . G ____

H Add lines A through G and enter total here. **Note:** This amount may be different from the number of exemptions you claim on your return. ▶ H ____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- If you are **single, have more than one job** and your combined earnings from all jobs exceed $32,000, OR if you are **married** and have a **working spouse or more than one job** and the combined earnings from all jobs exceed $55,000, see the Two-Earner/Two-Job Worksheet on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Cut here and give the certificate to your employer. Keep the top part for your records.** ----------

Form **W-4** (Department of the Treasury, Internal Revenue Service)

Employee's Withholding Allowance Certificate

▶ **For Privacy Act and Paperwork Reduction Act Notice, see page 2.**

OMB No. 1545-0010

1999

1 Type or print your first name and middle initial | Last name | 2 Your social security number

Home address (number and street or rural route) | 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. *Note: If married, but legally separated, or spouse is a nonresident alien, check the Single box.*

City or town, state, and ZIP code | 4 If your last name differs from that on your social security card, check here. You must call 1-800-772-1213 for a new card . . . ▶ ☐

5 Total number of allowances you are claiming (from line H above or from the worksheets on page 2 if they apply) . | 5 ____

6 Additional amount, if any, you want withheld from each paycheck . . . . . | 6 $ ____

7 I claim exemption from withholding for 1999, and I certify that I meet **BOTH** of the following conditions for exemption:
- Last year I had a right to a refund of **ALL** Federal income tax withheld because I had **NO** tax liability **AND**
- This year I expect a refund of **ALL** Federal income tax withheld because I expect to have **NO** tax liability.

If you meet both conditions, write "EXEMPT" here . . . . . ▶ | 7 ____

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's signature (Form is not valid unless you sign it) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete 8 and 10 only if sending to the IRS) | 9 Office code (optional) | 10 Employer identification number

Deductions and Adjustments Worksheet

Note: *Use this worksheet only if you plan to itemize deductions or claim adjustments to income on your 1999 tax return.*

1 Enter an estimate of your 1999 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (but not sales taxes), medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 1999, you may have to reduce your itemized deductions if your income is over $126,600 ($63,300 if married filing separately). Get Pub. 919 for details.) . . . 1 $

2 Enter: { $7,200 if married filing jointly or qualifying widow(er) / $6,350 if head of household / $4,300 if single / $3,600 if married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If line 2 is greater than line 1, enter -0- . . . . . 3 $

4 Enter an estimate of your 1999 adjustments to income, including alimony, deductible IRA contributions, and student loan interest . . 4 $

5 **Add** lines 3 and 4 and enter the total . . . . . 5 $

6 Enter an estimate of your 1999 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. Enter the result, but not less than -0- . . . . . 7 $

8 **Divide** the amount on line 7 by $3,000 and enter the result here. Drop any fraction 8

9 Enter the number from Personal Allowances Worksheet, line H, on page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the Two-Earner/Two-Job Worksheet, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, on page 1 10

Two-Earner/Two-Job Worksheet

Note: *Use this worksheet only if the instructions for line H on page 1 direct you here.*

1 Enter the number from line H on page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here 2

3 If line 1 is **GREATER THAN OR EQUAL TO** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter -0-) and on Form W-4, line 5, on page 1. **DO NOT** use the rest of this worksheet 3

Note: *If line 1 is **LESS THAN** line 2, enter -0- on Form W-4, line 5, on page 1. Complete lines 4–9 to calculate the additional withholding amount necessary to avoid a year end tax bill.*

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding amount needed 8 $

9 Divide line 8 by the number of pay periods remaining in 1999. (For example, divide by 26 if you are paid every other week and you complete this form in December 1998.) Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

Table 1: Two-Earner/Two-Job Worksheet

Married Filing Jointly

If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $4,000	0	40,001 - 45,000	8
4,001 - 7,000	1	45,001 - 54,000	9
7,001 - 12,000	2	54,001 - 62,000	10
12,001 - 18,000	3	62,001 - 70,000	11
18,001 - 24,000	4	70,001 - 85,000	12
24,001 - 28,000	5	85,001 - 100,000	13
28,001 - 35,000	6	100,001 - 110,000	14
35,001 - 40,000	7	110,001 and over	15

All Others

If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	65,001 - 80,000	8
5,001 - 11,000	1	80,001 - 100,000	9
11,001 - 16,000	2	100,001 and over	10
16,001 - 21,000	3		
21,001 - 25,000	4		
25,001 - 40,000	5		
40,001 - 50,000	6		
50,001 - 65,000	7		

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly		**All Others**	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $50,000	$400	$0 - $30,000	$400
50,001 - 100,000	770	30,001 - 60,000	770
100,001 - 130,000	850	60,001 - 120,000	850
130,001 - 240,000	1,000	120,001 - 250,000	1,000
240,001 and over	1,100	250,001 and over	1,100

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a **properly** completed form **will** result in your being treated as a single person who claims no withholding allowances; **providing fraudulent information may also subject you to penalties.** Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, and the District of Columbia for use in administering their tax laws.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is: **Recordkeeping** 46 min., **Learning about the law or the form** 10 min., **Preparing the form** 1 hr., 10 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. **DO NOT** send the tax form to this address. Instead, give it to your employer.